However, it should be suspected in patients with cardiogenic shock and pulmonary edema in the presence of atrial fibrillation and mitral valve disease, especially mitral stenosis. In our patient, previous mitral stenosis was aggravated by a thrombus penetrating the left ventricle, which caused mechanical mitral insufficiency. Surgical removal of the thrombi with simultaneous treatment of the underlying cause, in this case replacement of the mitral valve, and subsequent anticoagulation is the therapy of choice.[4,5]

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Patients with truncus arteriosus do not have a patent arterial duct: True or false?

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It is commonly believed that in the absence of aortic arch interruption,[1] neonates given diagnoses of truncus arteriosus (or common arterial trunk [CAT]) should not have coexistence of a patent ductus arteriosus (PDA). Simultaneous presence of a PDA and CAT has been reported with extreme rarity.[2] Figure 1 shows an intraoperative photograph taken during the complete repair of a 3.4-kg newborn with type II CAT (Collett and Edwards classification[3]). The right and left branch pulmonary arteries are retracted on snares, and between their respective origins from the arterial trunk, a PDA is seen joining the pulmonary arterial confluence and the uninterrupted aortic isthmus.

In the 1976 classic article describing clinical, angiocardiographic, and pathologic findings in 100 patients with CAT,[3] a PDA was observed in 14 patients. Among these, aortic arch interruption and anomalous ductal origin of the pulmonary artery were present in 10 and 2 patients, respectively. A PDA was well documented in only 2% of patients without the above-mentioned associated anomalies.

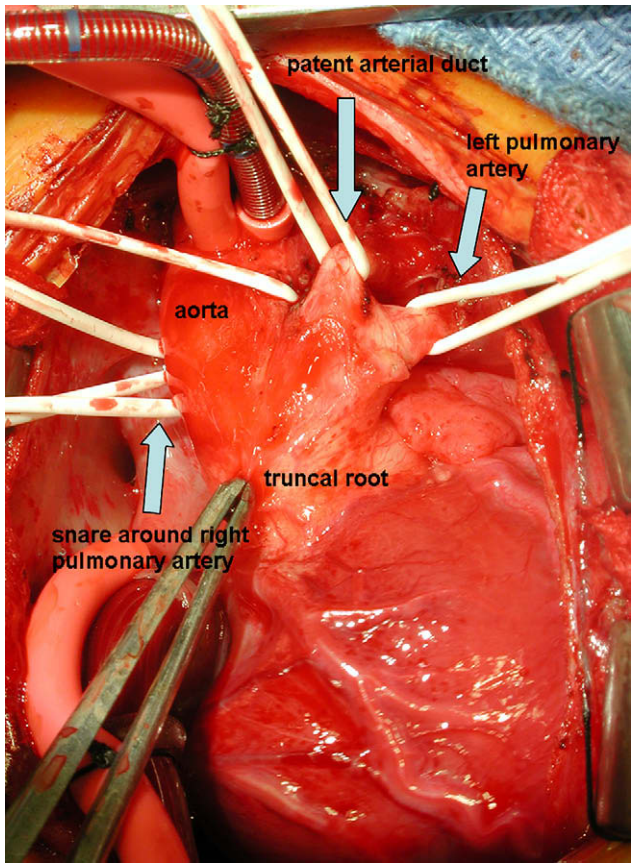

FIGURE 1. Intraoperative photograph of a newborn with type II CAT.

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